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DOCKET NO.:

UNITED STATES SUPREME COURT

OCTOBER TERM: OCTOBER 1996

JEANNE ELLIS,	)
	)
Petitioner,	)
	)
v.	)
	)
TRANSAMERICA OCCIDENTAL LIFE INSURANCE COMPANY,	)
	)
Respondent.	)
	)

On petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

---

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. In this ERISA case, did the lower courts apply the correct standard of review regarding Respondent's denial of Petitioner's death benefits claim?

2. Was Respondent's denial of death benefits in contravention of congressional policy and intent under ERISA, as interpreted by this Court?

3. Was the decision of the United States Court of Appeals in conflict with holdings within its own circuit and those of other circuits on the issue of insurance contract interpretation, and issues of causation of death under death and disability insurance policies?

4. Was petitioner denied fundamental civil due process rights when the lower courts, in effect, approved and adopted the decision of respondent's claim staff in denying the benefit claim?

5. Were questions a fact raised in the underlying cross-motions for summary judgment that were ignored by the lower courts, particularly on the issue of causation?

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I

PERTINENT OFFICIAL REPORTS AND ORDERS ENTERED IN THE CASE BY THE COURTS

1. A Memorandum of a non-published opinion of the United States Court of Appeals for the Ninth Circuit, D.C. No. 95-17204, dated February 20, 1997, denying petitioners appeal, Honorable Circuit Judges: Goodman, Levy and Thomas (Appendix "A")

2. An Order of the Honorable James Ware, United States District Judge denying petitioners motion for summary judgment and granting respondents under the United States District Court, Northern District of California, No. CV-94-20754-JW, dated September 28, 1995 (Appendix "B")

3. An Order denying petition for rehearing, United States Court of Appeal for the Nine Circuit, dated April 18, 1997, Honorable Circuit Judges: Goodman, Levy and Thomas (Appendix "C")

II

DESCRIPTION OF THE OFFICIAL OPINIONS AND ORDERS ENTERED BY THE LOWER COURTS AND JURISDICTIONAL STATEMENT

1. The date of the entry of the decision being reviewed is February 20, 1997; the unpublished Memorandum of decision of the United States Court of Appeals for the Ninth Circuit (Appendix "A")

2. The date of the Order denying rehearing on the Memorandum of decision of the United States Court of Appeal for the Ninth Circuit is April 18, 1997 (Exhibit "C")

3. The date of Order of the United States District Court for the Northern District of California granting Respondent's Motion for Summary Judgment and Denying Petitioner's Motion for Summary Judgment is September 28, 1995 (Exhibit "B")

4. The statute confirming jurisdiction in this Court is to review the judgment of the lower courts, supra, **28 United States Code §**

2101, and **United States Supreme Court Rules, Rule 13.1** and **Rule 13.3.**

III

CITATION OF STATUTES INVOLVED

The federal statute which is the basis for this action is the **Employee Retirement Income Security Act of 1974** ("ERISA"), **29 United States Code §§ 1001, et seq.**, excerpts of which are set forth in Appendix "D" as follows:

Section 1001, "Congressional Findings and Declaration of Policy"

Section 1001, "Definitions"

Subsection (1)(8)(14)(21A)

Section 1132, "Civil Enforcement"

Subsection (a)(1)(b)

IV

STATEMENT OF THE CASE

FACTUAL AND PROCEDURAL BACKGROUND

Petitioner, JEANNE ELLIS, is the surviving widow of PAUL LEE ELLIS II, who died on March 26, 1992, when he suffered a fall and struck his head at his work place, Lockheed Space & Missile Division in Sunnyvale, California. At the time of his death he was afforded coverage by his employer under an accidental death or disability insurance policy issued by Respondent, TRANSAMERICA OCCIDENTAL LIFE INSURANCE COMPANY. Petitioner submitted a claim for accidental death benefits in a principal sum of $275,000.00 to Lockheed who forwarded the claim to Respondent.

Respondent's claims personnel denied the claim, denied a subsequent "Appeal", and refused to pay the claim, on the alleged basis that the cause of death was not accidental and that under the policy (Appendix "E") Mr. Ellis suffered a "seizure" then fell and then died, and that seizure is the cause of death and not covered under the term "accident." Respondent also argued that a "disease" exclusion in the

policy applies (Appendix "E"). Respondent TRANSAMERICA further asserted that it's decision was absolutely unassailable and final as it is the "fiduciary" and appointed agent for settlement of claims filed against itself for payment of its insurance proceeds and that its decision cannot be questioned. Further Respondent argued that the Federal District Court and, later the Court of Appeals, were without authority to review and overturn TRANSAMERICA's all-prescient denial of the claim because the **Employee's Retirement Income Security Act (29 USC 1001, et seq.**, hereafter "ERISA") vests this "de facto" absolute discretion with Appellee as a "fiduciary" (Appendix "E".)

Upon consideration of cross Motions for Summary Judgment, the United States District Court for Northern California granted Respondent's motion, denied Petitioner's motion and entered judgment in favor of Respondent for reasons set forth in it's Memorandum Decision (Appendix "B".)

Petitioner herein appealed from that Order and Judgment, and requested that the United States Court of Appeals for the Ninth Circuit review the motions "de novo," find that the arbitrary denial by Respondent herein of Petitioner's claim was subject to independent review, that the federal common law governing the issues of policy interpretation compelled judgment in Petitioner's favor, and to enter judgment in favor of Petitioner as a matter of law, or in the alternative, remand this matter for trial by the District Court as issues of fact remain unresolved, principally the legal cause of death. Judge Ware in his Order (Appendix "B", pg. 6, ln. 22 to pg. 7, ln. 4) states: "It is unclear, even to the Court today, what precisely caused Plaintiff's death. Did Plaintiff suffer a seizure? Did Plaintiff merely fall and then suffer a seizure as a result of the fall? Could Plaintiff have survived had he been kept in the hospital instead of released and sent home? Since these questions remain unresolved, the Court cannot conclude that Plaintiff's husband's death resulted 'directly and independently of all other causes from bodily injury caused by accident.'" Such doubt indicates that a factual issue remains unresolved. Petitioner submits

based on the basis alone the motion should never have been granted.

The Court of Appeals denied Petitioner's appeal in an unpublished Memorandum (Appendix "A") and denied the motion for rehearing (Appendix "C".)

It is from this denial of Appeal and denial of rehearing that Petitioner files her Petition for Writ of Certiorari requesting that the United States Supreme Court grant review of the orders of the underlying courts for the reason stated herein.

Petitioner's Complaint was originally filed in the California Superior Court but was removed to the United States District Court on the basis that the U.S. District Court had concurrent jurisdiction under **29 USC § 1132(e)(1)**.

V

ARGUMENT

A. The District Court And The Court Of Appeals Erroneously Selected And Applied The Arbitrary And Capricious Standard Of The Review Of Denial Of Benefits By The Respondent

1. The Lower Courts' Holdings

Judge Ware, in the first instance in the District Court, operating under the assumption that he was bound to the arbitrary and capricious standard of review, (Exhibit "B") opined:

> "Although the Court agrees with Plaintiff that the appearance of a conflict might exist in this instance, Plaintiff has not submitted any material, probative evidence, which shows that a breach of fiduciary duty actually occurred. **Atwood v. Newmont Gold Co., Inc. 45 F.3d 1317, 1323 (9th Cir. 1995)**. Therefore the Court must apply the traditional abuse of discretion or arbitrary and capricious standard in reviewing Defendant's decision to deny Plaintiff benefits."

It is unclear exactly what degree of standard of review was applied by the Circuit Court of Appeals although it does make reference to the **Atwood** case. The Court also makes reference (Appendix "A") to the standard of review for the District Court's determinations as being "de novo." Since the Court of Appeals adopted the District Court's holding, we must conclude that the **Atwood** arbitrary and capricious standard was adopted and applied concerning the review of the Respondent's denial of the benefits in both of the lower courts.

2. Atwood Is Anomalous And Contrary To ERISA Policy

Atwood held:

> "The less differential standard under which we review apparently conflicted fiduciaries has two steps. First, we must determine whether the effected beneficiary has provided material, probative evidence, beyond the mere fact of apparent conflict tending to show that the fiduciary self interest caused a breach of the

administrator's fiduciary obligations to the beneficiary. If not, we apply our traditional abuse of discretion review." (Id. at 1323, Emphasis added.)

The **Atwood** ruling relied upon by Respondent and applied by the lower courts is contrary to the policy of the ERISA statute.

ERISA enacted in 1974 (**29 USC § 1461**) included a "declaration of policy" and stated, in part, with regard to employee benefit plans:

> "It is desirable in the interest of employees and their beneficiaries ... that safeguards be provided with respect to the establishment, operation, and administration of such plans."
>
> "It is therefore desirable . . . [that] the minimum standards be provided assuring the equitable character of such plans . . . [**29 USC § 1001(a)** Exhibit "D.]"
>
> Congress then stated, in part (**29 USC § 1001(b)**):
>
> "It is hereby declared to be the policy of this Act to protect . . . the interest of participants . . . and their

beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries . . . and by providing for appropriate remedies . . . and ready access to the federal courts (Emphasis added, Exhibit "D".)

The insurance company is a fiduciary where it has authority to grant or deny claims under ERISA, **McLaughlin v. Com. Gen. Life Ins. Co. 565 F.Supp. 434 (1983, N.D. Cal.), (Appendix "D" and "E")**

Four principles evolve out of the above: (a) Congress desired to regulate interstate commerce in relation to such benefit plans and to establish standards for the creation and administration of such plans (See: **Firestone Tire & Rubber Co. v. Bruch (1989) 489 US 101),** (b)) "ERISA was enacted to promote the interests of employees and their beneficiaries in employment benefit plans"; (c) Congress desired to protect the interest of employees and their beneficiaries who are entitled to benefits under the said plans; (d) Congress stated that these individuals who had discretionary authority to administer and grant or deny benefits would be held to the high standard of duty of

"fiduciaries" of the interested parties, particularly those of the employee and his/her beneficiaries; (e) congress specifica ıed to employees and beneficiaries "appropriate remedies" and "ready access to the federal courts."

Unfortunately, in the earlier case law interpreting ERISA, and even today, certain of these basic principles seem to have been overlooked or at least downplayed. **Atwood**, supra, if applied blindly, contains such an impairment. Fortunately, the United States Supreme Court, courts of other circuits, and other panels in the Ninth Circuit have seen the wisdom of adhering to the policy of safeguarding the rights of beneficiaries and holding the conflicted "fiduciary" to the higher standards intended by Congress, when appropriate.

"ERISA does not set out the appropriate standard of review for actions under **§1132(a)(1)(B)**." "To fill the gap the federal courts have adopted the arbitrary and capricious standard determined under **29 USC §186(c)**" of the **Labor Management Relations Act of 1947** (hereinafter "LMRA") "Comparison of the LMRA and ERISA, however, shows that the wholesale importation of the arbitrary and

capricious standard into ERISA is unwarranted." (**Firestone**, supra.) For example, "The LMRA does not provide for judicial review of the decisions of LMRA trustees of pension plans." Whereas ERISA specifically provides for such judicial review. "The federal courts adopted the arbitrary and capricious standard both as a standard of review and, more importantly, as a means of asserting jurisdiction over suits under Section 186(c)." (**Firestone**, supra)." "Thus, the 'raison d'etre' for the LMRA arbitrary and capricious standard - the need for jurisdictional basis in suits against trustees - is not present in ERISA." "Without the jurisdictional analogy, LMRA principals offer no support for the application of the arbitrary and capricious standard insofar as **§1132(a)(1)(B)** is concerned." (**Firestone**, supra., I.d. at p. 110.)

Thus, this Supreme Court decided to reign in the automatic application of the arbitrary and capricious standard of review by federal courts when ERISA claims decisions are contested by insureds or beneficiaries under **§1132(a)(1)(B)**. The "standard of review" in such circumstances has continued to evolve in favor of expanding liberality of judicial review when appropriate (notwithstanding **Atwood**, supra.)

Petitioner submits that the policy of the law governing the actions of trustee/fiduciaries in ERISA cases requires, and should require, that where the fiduciary is shown to have obtained, or more importantly created, a financial or other benefit to the detriment of the beneficiaries of the plan, for which he acts as a fiduciary, the burden is placed upon the fiduciary to come forward and show that its decisions leading to the self-benefit were proper and the results were for the benefit of the beneficiary. This is certainly the message in other cases that will be discussed. (Subsections (3) and (4) infra; see also the Restatement of Trusts, quoted with approval in **Firestone**, supra.)

3. The Conflict Of Authority Within The 9th Circuit Should Be Reconciled

The same week when **Atwood** was decided, another panel of the 9th Circuit arrived at a completely contrary ruling in **Parker v. Bank America Corp. (9th Cir. 1995) 50 F.3d 757**. The **Parker** Court of Appeals held that it was clear that the "fiduciary" had a conflict of interest because of its "dual position" as a "plan administrator" and as the entity whose financial liability was at stake.

(It would cost the fiduciary money if the beneficiaries' claim was upheld), "that this financial self-interest is sufficient to require a heightened and less differential review." The **Parker** court did not require the beneficiary to present any evidence of the conflict of interest, i.e., the obvious financial self-interest was sufficient.

The holding in **Pilon v. Retirement Plan (9th Cir. 1988) 861 F.2d 217**, which preceded **Parker**, foreshadows the **Parker** holding, and cites certain factors that militate in favor of a heightened review, one of which such factors is that the decision of the administrator is erroneous as a matter of law. (I.d. p. 218.).

In **Salterelli v. Bob Baker (9th Cir. 1994) 35 F.3d 382**, the court applied the de novo standard in a conflict situation. Therefore, simply applying the weight of other 9th Circuit cases, when the obvious conflict was apparent, Petitioner became entitled to a "heightened" review of the decision of the Respondent to deny benefits, and Petitioner submits that this should be under a totally "de novo" standard of review.

Furthermore, Petitioner is entitled to have a totally "de novo" review of applicable legal issues to include that of the proper selection of law applied in the interpretation of the contract, as well as the insurance coverages, which must be evaluated pursuant to the rules of the federal common law in further interpretation of the insurance contracts which, for example, require the interpretation of an insurance contract in favor of the insureds and the beneficiaries where ambiguities, by law, were found to exist (the "Contra Proferentum Rule," or **Kunin v. Benefit Trust, et al. (9th Cir. 1990) 910 F.2d 534**).

4. The Ruling In **Atwood** And The Lower Courts' Adherence To Its Arbitrary And Capricious Standard Is Contrary To Current Case Law Established In The Sister Circuits As Follows:

Anderson v. Great West. Life Assur. Co. (6th Cir. 1991) 942 F.2d 392, "discretion of the fiduciary is the exception, not the rule and such discretion is not an all or nothing proposition."

Brown v. Blue Cross/Blue Shield of Ala. Ins. (11th Cir. 1990) 898 F.2d 1556, a conflict of interest, such as financial self-interest, shifts the burden to the fiduciary to prove its denials of benefits were not tainted by such self-interest. The presence of an improper motive is a factor to consider.

Lee v. Blue Cross/Blue Shield of Ala., Inc. (11th Cir. 1994) 10 F.3d 1547, the burden passes to the fiduciary to nullify an apparent conflict of financial interest.

LeFabre v. Westinghouse Elect. Corp. (4th Cir. 1984) 747 F.2d 197, 204, the reviewing court must first determine if the trustee's decision was supported by "substantial evidence", similar to a review for a "directed verdict."

It is clear that the **Atwood** holding is anomalous and its application herein is not warranted.

B. The Respondent's Denial Of Benefits Was In Contravention Of Congressional Policy And Intent Under ERISA , As Interpreted By This Court

Petitioner, supra, has addressed the "policy" provisions of the ERISA statute, i.e., Section 1001 including subsections 1001(a) and (b) (Appendix "D").

Petitioner submits that the intent voiced by congress, which is in part (1) to protect the interest of employees and their beneficiaries under ERISA plans; (2) to establish standards of conduct, responsibilities, and obligations for fiduciaries; and (3) provide for appropriate remedies, sanctions, and ready access to the Federal Courts, are not upheld when self-serving and conflicted decisions to deny benefits by fiduciaries are permitted without the application of very close scrutiny by the courts.

Pursuant to **29 USC §1132(a)(1)(B)**, a beneficiary may bring a civil action to recover benefits due to him (sic) under the terms of the ERISA plan (Appendix "D"). Petitioner is such a beneficiary under the Respondent's death and disability plan (**29 USC §1002(1)(A); (5); (6); (7)** and **(8)**, Appendix "D" and "E").

Petitioner and others like her are entitled to the full rights and protections mandated by the statute, and Petitioner submits that, in this instance, she is being deprived of her rightful benefits due to the prima facie bad-faith conduct of Respondent's claim personnel, and the unfortunate incorrect application of the statutory and federal common law in adjudicating her claim.

In **Firestone**, supra, the court stated:

> "ERISA was enacted to promote the interest of employees and the beneficiaries in employee benefit plans (citation) and to protect contractually defined benefits (citation)." (Id. p. 956)

The **Firestone** court in rejecting Firestone's argument stated:

> "Adopting Firestone's reading of ERISA (demanding the arbitrary and capricious standard) would require us to impose a standard of review that would offer less protection to employees and

their beneficiaries than they enjoyed

before ERISA was enacted."

The current standards of enforcement available to the beneficiary, Petitioner submits, affords an ERISA beneficiary who has been denied a claim for benefits less protection than she would have been afforded prior to ERISA under state and federal interpretative laws of insurance.

An anomalous situation has evolved wherein an insurance company can write into its insurance plan with an employer that it will retain the absolute dictatorial powers of claims determination with respect to lay beneficiary claimants with great impunity. The fox has been allowed to guard the henhouse.

ERISA providers of insurance are not subject to actions for breach of the requirement of good-faith and fair dealing with its claimants, e.g., in California such a breach is actionable. (**Comunale v. Traders & General Ins. Co. (1958) 50 Cal.2d 654**.) Such a carrier is immune from enforcement of insurance regulatory provisions concerning fair claims administration (e.g., **California Insurance**

Code §790.03(h).) The only "control" that exists is a review by the courts of "arbitrary and capricious conduct" of its claim staff modified in various ways depending upon the District and Circuit Court jurisdiction. This rule imposes an unjust and unfair burden upon lay claimants; witness the holding in **Atwood**, supra.

The ERISA statute affords insureds and beneficiaries "ready access to federal courts" [**29 USC §1001(b)**]. This congretional statement means more than merely the right to file a lawsuit. It must also mean the right to "ready access to" the power and authority of the federal courts to protect the claimant under an ERISA insurance program from a self-serving secretive claims process by the insurance carrier. Anything less is contrary to the plain language of the statute and an abandonment of the charge placed upon the courts by a congretional enactment. But for the "arbitrary and capricious standard" employed by the lower federal courts Petitioner submits that she would, at least, have had her day in court, and the protection of the court in the application of the proper case law to the evidentiary facts established.

Petitioner respectfully requests and submits that this Supreme Court should address these problems, and as a matter of policy, fairness and equity, declare that a financially conflicted administrator, operating under a self-serving contract of its own creation, is not protected, under federal or state courts, by the "arbitrary and capricious" standard of review of its conduct in administering claims against it for monetary benefits. Only then will beneficiaries be afforded their rights envisioned by congress and as previously addressed by this Court.

C. The Decision Of The U.S. District Court And The Court Of Appeals Is In Conflict With The Federal Common Law Applicable To The Interpretation Of Insurance Contracts

Federal "courts are to develop a 'federal common law of rights and obligations under ERISA - regulated plans'", **Firestone**, supra, I.d. p. 954. Thus, the federal common law applicable to the interpretation of coverage issues in disputed claims cases, under life, accident, death and disability and medical insurance policy gradually evolved. This can include the adoption of case authorities from state courts [e.g., **Scott v. Gulf Oil Corp. (9th Cir. 1985) 754 F.2d 1499, 1502**].

In the lower courts, both parties cited **Garvey v. State Farm Fire & Casualty Co. (1989) 48 Cal.3d 395**, a landmark case.

Garvey stands for the proposition that when the cause of a loss under an insurance policy appears to involve two or more events leading to the loss, one covered and the other not, one must determine the presence of a compensable cause "under an efficient approximate cause analysis", sometimes referred to as "the predominant cause analysis". Where there is evidence of two such possible causative events, it is a question of fact as to which causal event controls. Here, as discussed in the lower court's decision (Appendixes "A" and "B") there is a suggestion that MR. ELLIS suffered a seizure of some kind, resulting in his uncontrolled and unintentional fall, which then resulted in the fatal trauma to his head when he struck a piece of metal at his work place. MR. ELLIS went to the hospital, seemed to recover, was sent home, and died approximately eight hours after his fall from the latent delayed effects of his fractured skull (Exhibits "A" and "B"). No knowledgeable person has yet to claim that he died as a result of a seizure.

If nothing else, there exists an issue of fact as to the predominant efficient cause of his death.

In denying the claim, the Respondents utilized early California state case rulings on the causation issue, which are in conflict with the more modern view such as in **Garvey**, supra. It is submitted that, when such errors of law have caused this meritorious claim to be denied the court reviews the law as applied "de novo". (See **Pilon**, supra, I.d. p. 218.)

The Court of Appeals cited **McClure v. Life Ins. Co. of No. America (9th Cir. 1996) 84 F.3d 1129**, (Appendix "A"), which was likewise cited by both parties. **McClure** addresses the rules to be applied in interpreting disability policies, and ratified much of Petitioner's arguments relating to the interpretation, in the federal courts, using federal common law, of death and disability policies. The **McClure** court reviewed and remanded a grant of summary judgment in favor of the Plaintiff. The court held: (1) State law does not control the construction of an ERISA POLICY. Such interpretation is governed by a uniform federal common law (emphasis added); (2)

Provisions in the policy "should be construed in a practical sense", i.e., in an "ordinary and popular sense as would a [person] of average intelligence and experience"; (3) ERISA policies are governed by the rule of contra proferentum [**Kunin v. Benf. Trust Life Ins. Co. 910 F.2d 534, 539-540 (9th Cir. 1990)**]; (4) The existence of a pre-existing condition does not bar recovery unless the condition "substantially" contributed to the disability (sic) loss (a fourth circuit rule); (5) The fourth circuit test requires a two-pronged analysis, (i) whether there is a pre-existing disease, pre-disposition, or susceptibility to injury; and (ii) whether the pre-existing condition, pre-disposition, or susceptibility substantially contributed to the loss [**Quisenberry v. Life Ins. Co. of No. Amer. 987 F.2d 1017, 1032 (4th Cir. 1993)** (Emphasis added)]; (6) The courts will protect the reasonable expectations of the insured, even though contrary to the expressed intention of the insurer; (7) One factor to be applied (**Henry v. Home Ins. Co. (C.D. CA 1996) 907 F.Supp. 1392)** is the "conspicuousness" of the policy phrase being addressed. The court on remand indicated that the district court should review and determine the reasonable expectations of the insured using

the fourth circuit test and the **Henry** (supra) test. If the policy passes the **Henry** test of conspicuousness, the court should then determine whether there is a triable issue as to whether the pre-existing condition substantially contributed to the disability condition using the fourth circuit test (**Quisenberry**, supra). McClure serves to establish arguments concerning the correct choice and applicability of the federal common law governing interpretation of coverage provisions in death and disability policies which Respondent's claims people chose to ignore, and the lower court's misinterpreted.

Petitioner was entitled to the full thrust and benefit of the federal common law but she did not receive that benefit. Under "de novo" review the lower courts were each required to determine whether the plan administrator utilized the proper law just as would occur should a party to an action challenge the law applied by any lower "judicial" type of authority. This Supreme Court is requested to review this area of law and to elucidate and articulate the applicable rules and clarify any conflicts, doubts or misconceptions as may exist within the body of the federal common law. In doing so, this Court is

empowered to remand this matter for further consideration in the lower courts, if nothing else.

D. Petitioner Was Denied Her Fundamental Civil Due Process Rights When The Lower Courts, In Effect, Approved And Adopted The Decision Of Respondent's Claim Staff In Denying The Benefit Claim

"Due process" concepts are often applied to "private transactions". They are sometimes referred to as "common law fair procedures". There is no real difference between "fair procedures" and "due process" rights, the distinction being in the origin rather than in the extent of the protection afforded to the individual, **Gill v. Mercy Hospital (1988) 199 Cal.App.3d 889, 897;** and also **Youngblood v. Wilcox (1989) 707 Cal.App.3d 1368, 1375,** where it was held that members of an unincorporated private association cannot be deprived of membership rights without charges, notice, and hearing even in absence of such rules. The same concept was iterated in **Ellis v. A.F. of L. (1941) 48 Cal.App.2d 440, 433-444.** The obligations to adhere to the principles of common law fair practice is based on the theory that

such institutions, such as hospitals, have fiduciary responsibilities, **Pinkster v. Pacific Coast Society of Orthodontics (1974) 12 Cal.3d 541, 550-554** and such requirements have been extended to private hospitals, **Ezekial v. Winkley (1972) 20 Cal.3d 272-278.** Petitioner submits that the Respondent, TRANSAMERICA, acting as a quasi judicial body, owed to Appellant the obligation to afford to her the common law right of fair procedural process, which equates to concepts of due process, required of government bodies. **(U.S. Constitution, Amendments V** and **XIV**.) This they failed to do.

Petitioner submits that Respondent, acting as a fiduciary in a quasi judicial capacity, denied Appellant her fundamental right to have her claim fairly reviewed within its own system, just as in a process of governmental due process, which equates to fair procedural process.

The Petitioner represents that Respondent did not comply with **29 CFRCH XVII, §2560.503-1** "Claims Procedure" particularly subsection (g) "Review Procedure" including subsection (iii) the right to review pertinent documents. Also, she was never advised of the extent of any investigation undertaken by Respondent's claim staff, the

explanations for denial of coverage were inadequate and in error according to law, there was no true "appellant process", and on remand, these issues, presented briefly in the underlying moving papers, should be re-examined. This Supreme Court and the Federal Courts have an opportunity to establish law that would provide to ERISA beneficiaries at least minimal due process and fair practice requirements.

E. Questions Of Fact Were Raised In The Underlying Cross Motions For Summary Judgment That Were Ignored By The Lower Courts Particularly On The Issue Of Causation And Policy Interpretation

As has been argued above, the issue of causation is a question of fact. Therefore, Petitioner was entitled to present her case to a trier of fact based upon an open courtroom trial, following additional discovery, particularly as to the issues of the inner machinations of the Respondent's claim staff. As indicated above, the actual cause of death became a disputed issue when Respondents raised the issue and argued that the seizure activity created the death.

Petitioner was entitled to a de novo review of that issue and was denied that review. Petitioner respectfully requests that this Court remand this matter to the lower courts for appropriate action in accordance with the holdings that we are requesting as presented above.

VI

CONCLUSION

Petitioner respectfully requests that the Honorable Supreme Court grant her Writ of Certiorari and either remand this matter to the lower court for further proceedings in accordance with the holdings of the Supreme Court, or in the alternative, request and indicate which further submissions should be made to this court in order to further consider the issues raised in this Petition.

DATED: July 16, 1997

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San Jose, CA 95113

Attorneys for Appellant
JEANNE ELLIS

APPENDIXES

Exhibit A

APPENDIX "A"

MEMORANDUM

NOT FOR PUBLICATION
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JEANNE ELLIS,
Plaintiff-Appellant,

No. 95-17205
D.C. No. CV-94-20754-J

MEMORANDUM*

v.

TRANSAMERICA OCCIDENTAL LIFE
INSURANCE COMPANY,
Defendant-Appellee

Appeal from the United States District Court
for the Northern District of California
James Ware, District Judge, Presiding

Argued and Submitted February 12, 1997**
San Francisco, California
Before: GOODWIN, LEAVY and THOMAS, Circuit Judges.

The parties are familiar with the facts of this case, and we will not restate them here. There are two issues presented in this appeal: (1) whether the administrator of an insurance contract governed by the Employee Retirement Income Security Act (ERISA) abused its discretion by denying benefits; and (2) if the administrator did not abuse its discretion, whether the insured nonetheless had reasonable expectations of coverage. After a thorough examination of the record and briefs, we affirm the district court's grant of summary judgment to Transamerica.

* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by 9th Cir. R. 36-3.

** The panel finds this case appropriate for submission without oral argument pursuant to 9th Cir. R. 34-4 and Fed. R. App. P. 34(a).

Standard of Review

Where an ERISA plan vests the administrator or fiduciary with discretionary authority to determine benefit eligibility, we review that decision for an abuse of discretion. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); see also Canseco v. Construction Laborers Pension Trust, 93 F.3d 600, 605 (9th Cir. 1996). If a plan administrator or fiduciary has a conflict of interest, that fact must be weighed in determining if there were an abuse of discretion. Firestone, 489 U.S. at 115; see also Snow v. Standard Ins. Co., 87 F.3d 327, 330 (9th Cir. 1996). A plan administrator has a conflict of interest if it has "an economic stake in the benefit decisions which it makes." Atwood v. Newmont Gold Co., 45 F.3d 1317, 1322 (9th Cir. 1995).

We review de novo a district court's grant of summary judgment, Baqdadi v. Nazar, 84 F.3d 1194, 1197 (9th Cir. 1996), and we review de novo the district court's determination that the administrator did not abuse its discretion in denying benefits. Snow, 87 F.3d at 331.

Interpreting the Language of the Contract

Medical reports contained in the record indicate the decedent died, at least in part, as a result of seizure activity. The insuring clause of Transamerica's plan, however, states that coverage will be provided only for "specified loss resulting directly and independently of all other causes from bodily injury caused by accident occurring while this policy is in force." The policy excludes coverage for "loss caused by or

resulting from . . [i]llness, disease, bodily infirmity or any bacterial infection other than bacterial infection occurring in consequence of an accidental cut or wound." The plan vests Transamerica with "discretionary authority to determine eligibility for benefits and to construe and interpret the plan/policy terms and provisions." We hold that Transamerica did not abuse its discretion in construing this language to deny benefits. See McClure v. Life Ins. Co., 84 F.3d 1129 (9th Cir. 1996) (holding under a de novo standard of review that identical exclusionary language would bar recovery of benefits if a preexisting condition contributed to the loss, even if the claimed injury was the predominant or proximate cause of the loss).

Reasonable Expectations of Coverage

The doctrine of reasonable expectations applies to ERISA governed insurance contracts. Saltarelli v. Bob Baker Group Med. Trust, 35 F.3d 382 (9th Cir. 1994). The doctrine provides that:

> [a]n insurer wishing to avoid liability on a policy purporting to give general or comprehensive coverage must make exclusionary clauses conspicuous, plain, and clear, placing them in such a fashion as to make obvious their relationship to other policy terms, and must bring such provisions to the attention of the insured. Id., at 386.

The exclusionary language in question is adequately clear. The policy states that it covers only loss resulting "directly" from accidents, and only if that loss resulted "independently of all other causes," including illness and disease.

The policy's limiting and exclusionary provisions are also conspicuous and plain. The illness/disease exclusion: (1) was set off in a separate paragraph; (2) was written in the same font and letter size as the rest of the contract; and (3) was placed under a bold-faced heading that used all capital letters. See Winters v. Costco Wholesale Corp., 49

F.3d 550, 555 (rejecting beneficiary's claim after finding similar clarity in plan's exclusionary clauses). The language limiting coverage to loss "resulting directly and independently of all other causes" is also quite conspicuous. Placed under the heading "PLAN SUMMARY," this language is contained in the first sentence of the first page of the contract.

For the above reasons, the decision of the district court is AFFIRMED.

Exhibit B

APPENDIX "B"

ORDER DENYING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

JEANNE ELLIS,	Case No. C-94-20754-JW
Plaintiff,	ORDER DENYING PLAINTIFF'S MOTION
vs.	FOR SUMMARY JUDGMENT AND
TRANSAMERICA OCCIDENTAL LIFE INSURANCE COMPANY, et al.	GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT
Defendants.	

I. INTRODUCTION

On September 8, 1995, the Court heard the parties' cross-motions for summary judgment. Plaintiff Jeanne Ellis ("Plaintiff)') moved for summary judgment on the basis that Defendant Transamerica Occidental Life Insurance Company ("Defendant") wrongfully denied her claims for benefits following the death of her insured husband, Paul Ellis. Defendant moved for summary judgment on the basis that its decision to deny Plaintiff's claim for benefits was correct and, in any event, must be afforded due deference by this Court and cannot be set aside unless found to be "arbitrary and capricious". Based upon all pleadings filed to date, as well as on the oral argument

of counsel, the Court DENIES Plaintiffs motion for summary judgment and GRANTS Defendant's motion, as discussed below.

II. BACKGROUND

Decedent Paul Ellis, Plaintiff's husband, was an employee of Lockheed Corporation ("Lockheed"). On September 1, 1990, Defendant issued a policy of Group Special Accident Insurance to Lockheed as part of an employee benefit plan. Both parties agree that the employee plan is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). The insuring clause of the insurance policy states that coverage will be provided for

specified loss resulting directly and independently of all other causes from bodily injury caused by accident occurring while the policy is in force.

The policy specifically excluded coverage for

loss caused by or resulting from ...
Illness, disease, bodily infirmity or any bacterial infection other than bacterial infection occurring as consequence of an accidental cut or wound.

On March 26, 1992, Paul Ellis was working at Lockheed when he appeared to suffer some type of seizure and fell to the ground, striking his head on a metal frame. His head immediately began to bleed. Mr. Ellis was taken to El Camino Hospital, where he was subsequently treated and released. Mrs. Ellis, upon her return home for lunch, was told by her husband that he had suffered a seizure at work and had been taken to the hospital, but that he was fine and that she should return to work. Mrs. Ellis went back to work and, upon her return home that evening, found Mr. Ellis laying on the bed, apparently unconscious. Mrs. Ellis called 911 and Mr. Ellis was transported to Good Samaritan Hospital, where he was pronounced dead. The death certificate stated that Mr. Ellis died due to:

Immediate Cause	Craniocerebral Injuries
Due To	Fall
Due To	Seizure Activity

In describing how the injury occurred, the death certificate stated that Mr. Ellis "fell during a seizure activity". (See Exhibit 2 to Declaration of Betty Watkins ("Watkins Declaration")). The coroner's report indicated that Mr. Ellis's death was caused by "cranio-cerebral injuries due to fall due to seizure activity" with "contributory fatty changes of the liver." (See Exhibit 3 to Watkins Declaration).

On May 19, 1992, Defendant received Plaintiffs claim under the policy issued to Paul Ellis for accidental death benefits. Plaintiff contends that the death of her husband was accidental and that, accordingly, she is entitled to benefits under the policy as beneficiary. Defendant denied Plaintiff's claim by letter dated June 30, 1992, on the basis that Mr. Ellis's death was not "accidental" since it was "caused by an episode of his epileptic illness". (See Exhibit 6 to Watkins Declaration).

Plaintiff appealed this decision and Defendant reevaluated Plaintiff's claim. By letter dated March 3, 1993, Defendant again denied Plaintiff's claim on the basis that the "disease exclusion" contained in the policy did not provide coverage for Mr. Ellis's death. The letter stated in part that "California law and ERISA enforce the disease exclusion if the fatal chain of events was precipitated by a disease process as the prime or moving cause".

Plaintiff then filed a complaint in state court, which was removed by Defendant to this Court on the basis of ERISA jurisdiction. The parties' cross-motions for summary judgment were then filed.

III. LEGAL STANDARDS

Summary judgment is proper "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). The purpose of summary judgment "is to isolate and dispose of factually unsupported claims or defenses." Celotex v. Catrett, 477 U.S. 317, 323-324 (1986).

The moving party "always bears the initial responsibility of informing the district court of the basis for its motion, and identifying those portions of 'the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any' which it believes demonstrate the absence of a genuine issue of material fact." Id. at 323. If he meets this burden, the moving party is then entitled to judgment as a matter of law when the non-moving party fails to make a sufficient showing on an essential element of his case with respect to which he bears the burden of proof at trial. Id. at 322-23.

The non-moving party "must set forth specific facts showing that there is a genuine issue for trial. " Fed. R. Civ. P. 56(e). The non-moving party cannot defeat the moving party's properly supported motion for summary judgment simply by alleging some factual dispute between the parties. To preclude the entry of summary judgment, the non-moving party must bring forth material facts, i.e., "facts that might affect the outcome of the suit under the governing law . Factual disputes that are irrelevant or unnecessary will not be counted." Anderson v. Liberty Lobby Inc., 477 U.S. 242, 247-48 (1986). The opposing party "must do more than simply show that there is some metaphysical doubt as to the material facts." Matsushita Elec. Indus. Co. v. Zenith Radio, 475 U.S. 574, 588 (1986).

The court must draw all reasonable inferences in favor of the non-moving party, including questions of credibility and of the weight to be accorded particular evidence. Masson v. New Yorker Magazine Inc., 111S.Ct.2419,2434-35 (1991) (citing Anderson, 477 U.S. at 255); Matsushita Elec. Indus. Co. v. Zenith Radio, 475 U.S. 574, 588 (1986); T.W. Elec. Service v. Pactfic Elec. Contractors, 809 F.2d 626, 630 (9th Cir. 1987). It is the court's responsibility "to determine whether the 'specific facts' set forth by the nonmoving party, coupled with undisputed background or contextual facts, are such that a rational or reasonable jury might return a verdict in its favor based on that evidence." T.W. Elec. Service, 808 F.2d at 631. "[S]ummary judgment will not lie if the dispute about a material fact is 'genuine,' that is if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." Anderson, 477 U.S. at 248. However, "[w]here the record taken as a whole could not lead a rational trier of fact to find for the non-moving-party, there is no 'genuine issue for trial."; Matsushita, 475 U.S. at 587.

IV. DISCUSSION

The United States Supreme Court has held that a court is required to make a de novo review of a fiduciary's claim decision under ERISA unless the plan gives the fiduciary or administrator discretionary authority to determine eligibility for benefits or to construe the plan. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). If such discretion is given, then the "arbitrary and capncious" standard applies. Id. The plan in this action undisputably afforded such discretion to Defendant. Therefore, Defendant contends that this Court must review its decision to deny benefits by applying the arbitrary and capricious standard.

Plaintiff argues that a "heightened standard" is appropriate, however, based upon the fact that here Defendant acted as both fiduciary and administrator of the plan, giving rise to an inference that a conflict of interest existed. Plaintiff argues that Defendant had a

vested interest in denying her claim since a denial would result in a savings of $275,000.00 to the plan.

Although the Court agrees with Plaintiff that the appearance of a conflict might exist in this instance, Plaintiff has not submitted any material, probative evidence which shows that a breach of fiduciary duty actually occurred. Atwood v. Newmont Gold Company, Inc.. 45 F.3d 1317, 1323 (9th Cir. 1995). Therefore, the Court must apply the traditional abuse of discretion or arbitrary and capricious standard in reviewing Defendant's decision to deny Plaintiff benefits.

Pursuant to such standard, Defendant's decision to deny Plaintiffs claim is afforded great deference. Plaintiff must show that Defendant's factual findings were clearly erroneous or that the terms of the plan were construed "in a way that clearly conflicts with the plain language of the plan", Johnson v. Trustees of W. Conf. Of Teamsters P.T. 879 F.2d 651, 654 (9th Cir. 1989). This is true even where, as here, Plaintiff contends that the policy language is ambiguous. Hancock v. Montgomery Ward Long Term Disability Trust, 787 F.2d 1302, 1308 (9th Cir. 1986).

Accordingly, applying the arbitrary and capricious standard, the Court cannot find that Defendant's decision to deny Plaintiff's claim was erroneous. Although the Court may not agree with the ultimate conclusion reached by Defendant, it cannot say that such decision was clearly unsupported by the language contained in the policy. It is unclear, even to the Court today, what precisely caused Plaintiff's death. Did Plaintiff suffer a seizure? Did Plaintiff merely fall and then suffer a seizure as a result of the fall? Could Plaintiff have survived had he been kept in the hospital instead of released and sent home? Since these questions remain unresolved, the Court cannot conclude that Plaintiff's husband's death resulted "directly and independently of all other causes from bodily injury caused by accident". Accordingly, the Court does not find that Defendant's decision to deny Plaintiff's claim for benefits was arbitrary and capricious.

V. CONCLUSION

Based upon the foregoing, the Court DENIES Plaintiff's motion for summary judgment and GRANTS Defendant's motion for summary judgment.

IT IS SO ORDERED.

DATED: September 27, 1995

JAMES WARE
United States District Judge

Exhibit C

APPENDIX "C"

ORDER DENYING REHEARING

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JEANNE ELLIS,	No. 95-17205 D.C. No. CV-94-20754-JW
Plaintiff-Appellant,	ORDER

v.

TRANSAMERICA OCCIDENTAL LIFE INSURANCE COMPANY,

Defendant-Appellee

Before: GOODWIN, LEAVY and THOMAS, Circuit Judges.

The petition for rehearing is denied.

APPENDIX "D"

STATUTORY PROVISIONS INVOLVED IN THE CASE

[U.S. Supreme Court Rules, Rule 14(1)(f)]

29 USC §§1001 et seq., Employee Retirement Income Security Act of 1974 (ERISA)

1. Section 1001 ("Congressional findings and declaration of policy")

> "**(a) Benefit plans as affecting interstate commerce and the Federal taxing power.** The Congress finds that the growth in size, scope and numbers of employee benefit plans in recent years has been rapid and substantial that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability for employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for a general welfare and the free flow of commerce, that disclosure be made and

safeguards be provided with respect to the establishment, operation, and administration of such plans that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is, therefore desirable in the interests of employees and their beneficiaries for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness."

Section 1001(b):

"(b) **Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries.** It is hereby declared to be the policy of this Act to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts."

2. Section 1002 ("Definitions")

Section 1002(1):

"For purposes of this title:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 [29 UCS §186(c)] (other than pensions on retirement or death, and insurance to provide such pensions)."

Section 1002(8):

"(8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder."

Section 1002(14)(A):

"The term "party in interest" means, as to an employee benefit plan -

(A) any fiduciary (including, but not limited to, any administrator, officer, trustee, or custodian), counsel, or employee of such employee benefit plan;"

Section 1002(21)(A):

"Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (I) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 405(c)(1)(B) [29 UCS §1105(C)(1)(B)]."

Section 1132 ("Civil Enforcement")

Section 1132(a):

"(a) **Persons empowered to bring a civil action**

A civil action may be brought -

(1) by a participant or beneficiary -

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms

of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan...;"

APPENDIX "E"

PROVISIONS OF THE SUBJECT DEATH AND DISABILITY POLICY

Respondent Transamerica relied on the following provisions of it's death and disability policy, which is extracted from it's brief filed in the United States Court of Appeals for the Ninth Circuit:

The insuring clause of the insurance certificate issued to Mr. Ellis offered coverage for

> "Specified loss resulting directly and independently of all of the causes from bodily injuries caused by accident occurring while this policy is in force.

An exclusionary clause of the insurance certificate excluded:

> Loss caused by a resulting from illness, disease, bodily infirmity, or any bacterial infection other than bacterial infection occurring in consequence of an accidental cut or wound.

A statement in the insurance certificate stated as follows:

> We are the fiduciary under the plan designated to review any claim appeals by claimant and are vested with discretionary authority to determine eligibility for benefits and to construe and interpret the plan/policy terms and provisions."